FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037838

Facility Name: OREGON HEALTHCARE CENTER

Address: 881 SOUTH 10TH STREET (Number) OREGON (City) 61061 (Zip Code)

County: OGLE

Telephone Number: (815) 732-7994 **Fax #** (815) 732-3733

IDPA ID Number: 363806980001

Date of Initial License for Current Owners: 03/01/92

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) NOSHIR R. DARUWALLA, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	104	Skilled (SNF)	104	37,960	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	104	TOTALS	104	37,960	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,900	747	1,489	6,136	8
9	SNF/PED					9
10	ICF	15,708	4,855	9	20,572	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,608	5,602	1,498	26,708	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.36%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 3/1/92

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/92 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 1184

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	172,953	12,482	5,848	191,283		191,283	(43)	191,240			1
2	Food Purchase		108,637		108,637		108,637	(227)	108,410			2
3	Housekeeping	144,411	47,434		191,845		191,845		191,845			3
4	Laundry	62,756	18,010		80,766		80,766		80,766			4
5	Heat and Other Utilities			75,529	75,529		75,529	512	76,041			5
6	Maintenance	37,123	36,865	7,786	81,774		81,774	(5,547)	76,227			6
7	Other (specify):*											7
8	**TOTAL General Services**	417,243	223,428	89,163	729,834		729,834	(5,305)	724,529			8
	B. Health Care and Programs											
9	Medical Director			3,450	3,450		3,450		3,450			9
10	Nursing and Medical Records	901,362	9,094	1,521	911,977		911,977	(2,779)	909,198			10
10a	Therapy			25	25		25		25			10a
11	Activities	49,726	3,376		53,102		53,102		53,102			11
12	Social Services	24,156			24,156		24,156		24,156			12
13	Nurse Aide Training			750	750		750		750			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	975,244	12,470	5,746	993,460		993,460	(2,779)	990,681			16
	C. General Administration											
17	Administrative	47,536		120,000	167,536		167,536	1,086	168,622			17
18	Directors Fees											18
19	Professional Services			104,305	104,305		104,305	(68,634)	35,671			19
20	Dues, Fees, Subscriptions & Promotions			14,865	14,865		14,865	(6,331)	8,534			20
21	Clerical & General Office Expenses	49,192	2,280	72,767	124,239		124,239	84	124,323			21
22	Employee Benefits & Payroll Taxes			214,123	214,123		214,123		214,123			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,565	1,565		1,565	(238)	1,327			24
25	Other Admin. Staff Transportation			2,719	2,719		2,719	1,215	3,934			25
26	Insurance-Prop.Liab.Malpractice			24,599	24,599		24,599	1,570	26,169			26
27	Other (specify):*							10,529	10,529			27
28	**TOTAL General Administration**	96,728	2,280	554,943	653,951		653,951	(60,719)	593,232			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,489,215	238,178	649,852	2,377,245		2,377,245	(68,803)	2,308,442			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number OREGON HEALTHCARE CENTER #0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			9,475	9,475		9,475	44,018	53,493			30
31	Amortization of Pre-Op. & Org.							3,436	3,436			31
32	Interest			45,926	45,926		45,926	(45,926)	(0)			32
33	Real Estate Taxes			30,335	30,335		30,335	2,456	32,791			33
34	Rent-Facility & Grounds			265,720	265,720		265,720	(265,720)				34
35	Rent-Equipment & Vehicles							867	867			35
36	Other (specify):*											36
37	**TOTAL Ownership**			351,456	351,456		351,456	(260,869)	90,587			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		27,353	56,753	84,106		84,106	(102)	84,004			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,940	56,940		56,940		56,940			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		27,353	113,693	141,046		141,046	(102)	140,944			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,489,215	265,531	1,115,001	2,869,747		2,869,747	(329,774)	2,539,973			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10,126	30		9
10	Interest and Other Investment Income	(21,763)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(227)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(41,020)	21		18
19	Entertainment				19
20	Contributions	(3,751)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,886)	21		24
25	Fund Raising, Advertising and Promotional	(546)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,206)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(107,442)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (167,715)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(162,059)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (162,059)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (329,774)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

OREGON HEALTHCARE CENTER

ID# 0037838

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Replacement Tax - Oregon Associates	$ (3,798)	21	1
2	VA Expenses - Pharmacy	(2,779)	10	2
3	PAC dues - IL Council LTC	(2,085)	20	3
4	Cable TV Income - to offset expense	(1,022)	5	4
5	Misc Income - to write off due to prior owner	(90,899)	32	5
6	Out of period legal	(295)	19	6
7	Out of state seminar	(298)	24	7
8	Capitalized R&M	(6,266)	6	8
9				9
10				10
11				11
12				12
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91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(43)							(43)	1
2	Food Purchase	(227)											(227)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(1,022)		1,534									512	5
6	Maintenance	(6,266)		719									(5,547)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(7,515)		2,253		(43)							(5,305)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,779)											(2,779)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(2,779)											(2,779)	16
	C. General Administration													
17	Administrative			1,086									1,086	17
18	Directors Fees													18
19	Professional Services	(295)		(75,969)	7,630								(68,634)	19
20	Fees, Subscriptions & Promotions	(6,382)		51									(6,331)	20
21	Clerical & General Office Expenses	(47,910)	3,601	44,393									84	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(298)		60									(238)	24
25	Other Admin. Staff Transportation			1,215									1,215	25
26	Insurance-Prop.Liab.Malpractice			1,570									1,570	26
27	Other (specify):*			10,529									10,529	27
28	**TOTAL General Administration**	(54,885)	3,601	(17,065)	7,630								(60,719)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(65,179)	3,601	(14,812)	7,630	(43)							(68,803)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	10,126	32,028	1,864									44,018	30
31	Amortization of Pre-Op. & Org.		3,436										3,436	31
32	Interest	(112,662)	27,362	1,969	37,405								(45,926)	32
33	Real Estate Taxes			2,456									2,456	33
34	Rent-Facility & Grounds		(265,720)										(265,720)	34
35	Rent-Equipment & Vehicles			867									867	35
36	Other (specify):*													36
37	TOTAL Ownership	(102,536)	(202,894)	7,156	37,405								(260,869)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(102)							(102)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers					(102)							(102)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(167,715)	(199,293)	(7,656)	45,035	(145)							(329,774)	45

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 265,720	Oregon Associates	100.00%	$	$ (265,720)	1
2	V	32	Interest Income	108,563	Oregon Associates	100.00%		(108,563)	2
3	V	32	Interest Expense		Oregon Associates	100.00%	135,925	135,925	3
4	V	21	Replacement Tax		Oregon Associates	100.00%	3,798	3,798	4
5	V	30	Depreciation		Oregon Associates	100.00%	32,028	32,028	5
6	V	31	Amortization		Oregon Associates	100.00%	3,436	3,436	6
7	V	21	Gain/Loss on Partnership	197	Oregon Associates	100.00%		(197)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 374,480			$ 175,187	$ * (199,293)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.W. MANAGEMENT	100.00%	$ 1,534	$ 1,534	15
16	V	6	REPAIRS AND MAINT.		S.W. MANAGEMENT	100.00%	719	719	16
17	V	19	PROFESSIONAL FEES		S.W. MANAGEMENT	100.00%	731	731	17
18	V	20	FEES, SUBSCRIPTIONS, DUES		S.W. MANAGEMENT	100.00%	51	51	18
19	V	21	CLERICAL AND GENERAL		S.W. MANAGEMENT	100.00%	44,393	44,393	19
20	V	24	EDUCATION AND SEMINARS		S.W. MANAGEMENT	100.00%	60	60	20
21	V	25	TRANSPORTATION		S.W. MANAGEMENT	100.00%	1,215	1,215	21
22	V	26	INSURANCE - PROPERTY		S.W. MANAGEMENT	100.00%	1,570	1,570	22
23	V	27	PAYROLL TAXES		S.W. MANAGEMENT	100.00%	7,745	7,745	23
24	V	30	DEPRECIATION		S.W. MANAGEMENT	100.00%	1,864	1,864	24
25	V	32	INTEREST EXPENSE		S.W. MANAGEMENT	100.00%	1,969	1,969	25
26	V	33	REAL ESTATE TAXES		S.W. MANAGEMENT	100.00%	2,456	2,456	26
27	V	35	AUTO LEASE		S.W. MANAGEMENT	100.00%	867	867	27
28	V								28
29	V								29
30	V	17	SALARY - SHELDON WOLFE		S.W. MANAGEMENT	100.00%	56,086	56,086	30
31	V	17	SALARY - RONNIE KLEIN		S.W. MANAGEMENT	100.00%	5,000	5,000	31
32	V	27	EMP. BEN.-SHELDON WOLFE		S.W. MANAGEMENT	100.00%	2,088	2,088	32
33	V	27	EMP. BEN.-RONNIE KLEIN		S.W. MANAGEMENT	100.00%	696	696	33
34	V								34
35	V	17	MANAGEMENT FEES	60,000	S.W. MANAGEMENT	100.00%		(60,000)	35
36	V	19	HOME OFFICE FEES	76,700	S.W. MANAGEMENT	100.00%		(76,700)	36
37	V								37
38	V								38
39	Total			$ 136,700			$ 129,044	$ * (7,656)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	SFO ASSOCIATES	100.00%	$ 7,630	$ 7,630	15
16	V	32	INTEREST		SFO ASSOCIATES	100.00%	172,807	172,807	16
17	V								17
18	V								18
19	V								19
20	V	32	INTEREST	135,402	SFO ASSOCIATES	100.00%		(135,402)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 135,402			$ 180,437	$ * 45,035	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SUPPLEMENTS	$ 425	S & E MEDICAL SUPPLY	100.00%	$ 382	$ (43)	15
16	V	39	ANICILLARY EXPENSE	509	S & E MEDICAL SUPPLY	100.00%	407	(102)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 934			$ 789	$ * (145)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING & MEDICAL SUPPLY	$ 6,830	PHARMCOR, L.L.C.	100.00%	$ 6,830	$	15
16	V	39	ANICILLARY EXPENSE	12,257	PHARMCOR, L.L.C.	100.00%	12,257		16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 19,087			$ 19,087	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SHELDON WOLFE	President	Administrative	31.74%	See Attached	5	8.33%	Alloc SW Mg	$ 56,086	17-7	1
2	RONNIE KLEIN	Treasurer	Administrative	15.87%	See Attached	5	8.33%	Alloc SW Mg	5,000	17-7	2
3	RONNIE KLEIN							Fees Facility	60,000	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 121,086		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.W. MANAGEMENT
Street Address: 7434 N. SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIABLE BED DAYS	450,410	8	$ 18,206	$	37,960	$ 1,534	1
2	6	REPAIRS AND MAINT.	AVAIABLE BED DAYS	450,410	8	8,532		37,960	719	2
3	19	PROFESSIONAL FEES	AVAIABLE BED DAYS	450,410	8	8,672		37,960	731	3
4	20	FEES, SUBSCRIPTIONS, DUES	AVAIABLE BED DAYS	450,410	8	603		37,960	51	4
5	21	CLERICAL AND GENERAL	AVAIABLE BED DAYS	450,410	8	526,738	470,813	37,960	44,393	5
6	24	EDUCATION AND SEMINARS	AVAIABLE BED DAYS	450,410	8	710		37,960	60	6
7	25	TRANSPORTATION	AVAIABLE BED DAYS	450,410	8	14,421		37,960	1,215	7
8	26	INSURANCE - PROPERTY	AVAIABLE BED DAYS	450,410	8	18,629		37,960	1,570	8
9	27	PAYROLL TAXES	AVAIABLE BED DAYS	450,410	8	91,903		37,960	7,745	9
10	30	DEPRECIATION	AVAIABLE BED DAYS	450,410	8	22,118		37,960	1,864	10
11	32	INTEREST EXPENSE	AVAIABLE BED DAYS	450,410	8	23,361		37,960	1,969	11
12	33	REAL ESTATE TAXES	AVAIABLE BED DAYS	450,410	8	29,144		37,960	2,456	12
13	35	AUTO LEASE	AVAIABLE BED DAYS	450,410	8	10,285		37,960	867	13
14										14
15										15
16	17	SALARY - SHELDON WOLFE	AVG. HOURS WORKED	60	9	673,036	673,036	5	56,086	16
17	17	SALARY - RONNIE KLEIN	AVG. HOURS WORKED	60	7	60,000	60,000	5	5,000	17
18	27	EMP. BEN.-SHELDON WOLFE	AVG. HOURS WORKED	60	9	25,062		5	2,088	18
19	27	EMP. BEN.-RONNIE KLEIN	AVG. HOURS WORKED	60	7	8,356		5	696	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,539,776	$ 1,203,849		$ 129,044	25

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SFO ASSOCIATES
Street Address: 7434 N. SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	NOTE RECEIVABLE	6,500,000	3	$ 24,796	$	2,000,000	$ 7,630	1
2	32	INTEREST	NOTE RECEIVABLE	6,500,000	3	561,623		2,000,000	172,807	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 586,419	$		$ 180,437	25

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S & E MEDICAL SUPPLY
Street Address: 3100 COMMERCIAL AVENUE
City / State / Zip Code: NORTHBROOK, ILLINOIS 60062
Phone Number: (847) 982-9300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SUPPLEMENTS	DIRECT ALLOCATION			$	$		$ 382	1
2	39	ANICILLARY EXPENSE	DIRECT ALLOCATION						407	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 789	25

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PHARMCOR, L.L.C.
Street Address: 3116 S. OAK PARK
City / State / Zip Code: BERWYN, IL 60402
Phone Number: (708)795-7701
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING & MEDICAL SUPPLY	DIRECT ALLOCATION			$	$		$ 6,830	1
2	39	ANICILLARY EXPENSE	DIRECT ALLOCATION						12,257	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 19,087	25

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Oregon Associates	X					$	$ 707,224			$ 45,616	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 707,224			$ 45,616	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(181,852)	10
11	Insurance		X								310	11
12	Oregon Assoc	X						1,538,462			135,925	12
13												13
14	TOTAL Non-Facility Related						$	$ 1,538,462			$ (45,617)	14
15	TOTALS (line 9+line14)						$	$ 2,245,686			$ (1)	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Oregon Healthcare Center	X		Interest Income			$	$			$ (21,763)	1
2	Oregon Associates	X		Interest Income							(108,563)	2
3	Allocated SW Mgmt	X									1,968	3
4	Allocated SFO	X		Interest Income							(135,402)	4
5	Allocated SFO	X									172,807	5
6												6
7												7
8	write off of due to prior owner										0	8
9	adjusted out on p. 5		X								(90,899)	9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (181,852)	21

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		$ 28,147	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 30,984	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,837	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 29,954	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 32,791	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	25,718	8
1997	28,083	9
1998	27,868	10
1999	26,806	11
2000	28,528	12

2001 accrual = 28,527.80 x 1.05 = 29954.19
SW Mgmt allocation = 2,456
facility tax (28,528) + sw mgmt (2,456) = 30,984

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OREGON HEALTHCARE CENTER COUNTY OGLE

FACILITY IDPH LICENSE NUMBER 0037838

CONTACT PERSON REGARDING THIS REPORT STEVEN LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-16-04-476-009	Nursing home	$ 28,527.80	$ 28,527.80
2.	see attached	allocation from SW Mgmt	$ 30,227.00	$ 2,456.19
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 58,754.80	$ 30,983.99

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,900 B. General Construction Type: Exterior BRICK Frame STEEL STUD Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 113,078
2. Number of Years Over Which it is Being Amortized: 30
3. Current Period Amortization: 3,436
4. Dates Incurred: 1992

Nature of Costs: LOAN COSTS & MORTGAGE COSTS
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1992	$ 50,000	1
2					2
3	TOTALS			$ 50,000	3

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1992	6,160	-	20	318	318	6,032	9
10	Various			1993	26,517	320	20	1,325	1,005	11,541	10
11	Various			1994	5,324	-	20	266	266	2,247	11
12	Various			1995	3,498	312	20	175	137	1,152	12
13	Various			1996	2,042	52	20	102	50	543	13
14	Various			1997	2,880	199	20	144	(55)	660	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		1,053,545	33,302		30,334	(2,968)	319,660	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 1,099,966	$ 34,185		$ 32,664	$ (1,247)	$ 341,835	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,099,966	$ 34,185		$ 32,664	$ (1,521)	$ 341,835	1
2	PARKING LOT	1998	36,382	933	20	1,819	886	5,609	2
3	TELEPHONE SYSTEM	1998	4,327		20	216	216	987	3
4	COMPRESSOR	1998	3,095	357	20	155	(202)	568	4
5	KITCHEN	1998	19,340	2,228	20	1,934	(294)	5,802	5
6	AIR CONDITION	1998	1,911		20	191	191	573	6
7	SEWER PIPES	1999	4,075	104	20	204	100	612	7
8	FLOOR TILES,WALLPAPE	1999	11,750	301	20	588	287	1,519	8
9	FLOOR TILES,WALLPAPE	1999	5,302	136	20	265	129	685	9
10	100 AMP FEEDER	1999	7,800	200	20	390	190	813	10
11	AIR CONDITIONERS	1999	734	141	20	37	(104)	96	11
12	AIR CONDITIONERS	1999	1,369	263	20	68	(195)	170	12
13	CORDSET	1999	1,053	202	20	53	(149)	141	13
14	ALARM	1999	1,188	228	20	119	(109)	337	14
15	FIRE DOOR	1999	912		20	91	91	190	15
16	FLOOR TILE	1999	506		20	51	51	106	16
17	AIR CONDITIONER	1999	1,369	263	20	137	(126)	365	17
18	MODEL 10KPA CODE ALR	2001	1,189	238	20	25	(213)	25	18
19	GENERATOR REPAIR	2001	1,010		20	9	9	9	19
20	MOTOR	2001	783		20	26	26	26	20
21	GLASS THERMO UNIT	2001	868		20	22	22	22	21
22	INSTALL BOARD	2001	816		20	14	14	14	22
23	GAS CONTROLLER	2001	739		20	9	9	9	23
24	CLUTCH & OUTPUT BRD	2001	1,138		20	14	14	14	24
25	VINYL FLOORING	2001	912		20	42	42	42	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,208,534	$ 39,779		$ 39,143	$ (636)	$ 360,569	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,208,534	$ 39,779		$ 39,143	$ (636)	$ 360,569	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,208,534	$ 39,779		$ 39,143	$ (636)	$ 360,569	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,208,534	$ 39,779		$ 39,143	$ (636)	$ 360,569	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,208,534	$ 39,779		$ 39,143	$ (636)	$ 360,569	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,208,534	$ 39,779		$ 39,143	$ (636)	$ 360,569	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,208,534	$ 39,779		$ 39,143	$ (636)	$ 360,569	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 1,208,534	$ 39,779		$ 39,143	$ (636)	$ 360,569	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,208,534	$ 39,779		$ 39,143	$ (636)	$ 360,569	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 1,208,534	$ 39,779		$ 39,143	$ (636)	$ 360,569	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,208,534	$ 39,779		$ 39,143	$ (636)	$ 360,569	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 1,208,534	$ 39,779		$ 39,143	$ (636)	$ 360,569	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,208,534	$ 39,779		$ 39,143	$ (636)	$ 360,569	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 1,208,534	$ 39,779		$ 39,143	$ (636)	$ 360,569	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,208,534	$ 39,779		$ 39,143	$ (636)	$ 360,569	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	104		1992		$ 1,008,880	$ 32,028	35	$ 28,825	$ (3,203)	$ 310,404	4
5	SW MGMT		1995		36,569	938	35	1,045	107	6,953	5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATED SW MGMT			1995	3,892	201	20	232	31	1,494	9
10	ALLOCATED SW MGMT			1996	680	17	20	34	17	189	10
11	ALLOCATED SW MGMT			1997	979	53	20	70	17	299	11
12	ALLOCATED SW MGMT			1998	674	17	20	34	(17)	126	12
13	ALLOCATED SW MGMT			1999	1,871	48	20	94	46	195	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,053,545	$ 33,302		$ 30,334	$ (3,002)	$ 319,660	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 140,789	$ 1,290	$ 12,448	$ 11,158	10	$ 103,414	71
72	Current Year Purchases	9,757	2,298	1,902	(396)	10	1,902	72
73	Fully Depreciated Assets	215,432				10	215,432	73
74								74
75	TOTALS	$ 365,978	$ 3,588	$ 14,350	$ 10,762		$ 320,748	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,624,512	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 43,367	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 53,493	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,126	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 681,317	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation SW Mgmt		$	$ 866	17
18					18
19					19
20					20
21	TOTAL		$	$ 866	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [X] YES
   - [ ] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM: [ ]
   - IN OTHER FACILITY: [X]
   - COMMUNITY COLLEGE: [ ]
   - HOURS PER AIDE: 84

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM: [ ]
   - IN OTHER FACILITY: [X]
   - HOURS PER AIDE: 45

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 750	$	$ 750
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 750	$	$ 750
10	SUM OF line 9, col. 1 and 2 (e)	$ 750			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 22,189	$		$ 22,189	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			596			596	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			33,968			33,968	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				24,178		24,178	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						3,175		3,175	13
14	TOTAL			$		$ 56,753	$ 27,353		$ 84,106	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 84,349	$ 86,094	1
2	Cash-Patient Deposits	8,244	8,244	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	615,021	615,021	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,587	36,587	6
7	Other Prepaid Expenses	746	746	7
8	Accounts Receivable (owners or related parties)		1,351,627	8
9	Other(specify): See supplemental schedule	310,076	342,801	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,055,023	$ 2,441,120	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		1,008,880	14
15	Leasehold Improvements, at Historical Cost	82,699	82,699	15
16	Equipment, at Historical Cost	200,384	406,384	16
17	Accumulated Depreciation (book methods)	(193,508)	(713,115)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		113,078	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(35,543)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 89,575	$ 912,383	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,144,598	$ 3,353,503	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 136,198	$ 136,197	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,447	10,447	28
29	Short-Term Notes Payable	707,224	707,224	29
30	Accrued Salaries Payable	36,416	36,416	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,002	5,002	31
32	Accrued Real Estate Taxes(Sch.IX-B)	29,954	29,954	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 925,241	$ 925,240	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,538,462	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 1,538,462	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 925,241	$ 2,463,702	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 219,357	$ 889,801	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,144,598	$ 3,353,503	48

***(See instructions.)**

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 176,726	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 176,726	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	42,631	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 42,631	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 219,357	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,755,180	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,755,180	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	31,422	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 31,422	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	1,022	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,086	19
20	Radiology and X-Ray		20
21	Other Medical Services	5,453	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 10,561	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	23,216	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 23,216	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	91,999	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 91,999	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,912,378	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	729,834	31
32	Health Care	993,460	32
33	General Administration	653,951	33
	B. Capital Expense		
34	Ownership	351,456	34
	C. Ancillary Expense		
35	Special Cost Centers	84,106	35
36	Provider Participation Fee	56,940	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,869,747	40
41	**Income before Income Taxes (line 30 minus line 40)****	42,631	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 42,631	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,840	1,840	$ 39,405	$ 21.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,250	5,616	107,140	19.08	3
4	Licensed Practical Nurses	11,972	12,990	217,444	16.74	4
5	Nurse Aides & Orderlies	51,332	52,875	537,373	10.16	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,512	4,901	49,726	10.15	10
11	Social Service Workers	1,920	1,920	24,156	12.58	11
12	Dietician					12
13	Food Service Supervisor	1,894	2,141	22,895	10.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,926	19,975	150,058	7.51	15
16	Dishwashers					16
17	Maintenance Workers	2,115	2,389	37,123	15.54	17
18	Housekeepers	16,477	17,337	144,411	8.33	18
19	Laundry	9,148	9,507	62,756	6.60	19
20	Administrator	1,980	2,080	47,536	22.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,490	2,682	49,192	18.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	129,856	136,253	$ 1,489,215 *	$ 10.93	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	86	$ 5,848	01-03	35
36	Medical Director	92	3,450	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	32	1,521	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	1	25	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	211	$ 10,844		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	n/a	$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Debra Adkins	Administrator	0%	47,536
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 47,536

B. Administrative - Other

Description	Amount
Ronnie Klein	$ 60,000
SW Mgmt	60,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 120,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Winston & Strawn	legal	5,655
Frost, Ruttenber & Rothblatt	accounting	21,950
SW Mgmt	home office	76,700
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 104,305

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 36,678
Unemployment Compensation Insurance	12,592
FICA Taxes	113,874
Employee Health Insurance	49,660
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	1,041
Holiday Expense	278
TOTAL (agree to Schedule V, line 22, col.8)	$ 214,123

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	3,111
Health Care Worker Background Check	420
(Indicate # of checks performed 35)	
Association fees	3,228
Advertising & Promotion	546
Dues/Subscriptions	692
Inspections/Permits/Licenses	832
Allocation SW Mgmt	51
Less: Public Relations Expense	
Non-allowable advertising	(546)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,534

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Seminars	1,267
Allocation SW Mgmt	60
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,327

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	none		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LTC: 5313**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **56,940**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% In 1**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees